

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037797

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9821

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis, Mo.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>- - -</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Louis, Mo.</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>10 hours</u>		Inside Limits <u>Yes</u> <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis-Little Rock Hospital, Inc.</u>		d. STREET ADDRESS (If outside, give location) <u>5457 Delor St.</u>	
Reside on Farm <u>Yes</u> <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Joseph</u> Last <u>McCaffery</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>30</u> Year <u>1963</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-02</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>meat cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Supermarket</u>	
11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James J. McCaffery, Sr.</u>		13b. MOTHER'S MAIDEN NAME <u>Marie Joseph Scanlan</u>	
14. NAME OF HUSBAND OR WIFE <u>Geneva Hume McCaffery</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW I</u>		16. SOCIAL SECURITY NO. <u>331x</u>	
17. INFORMANT <u>Mrs. Geneva H. McCaffery</u>		Address <u>5457 Delor</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage, Pontine</u> DUE TO (b) <u>Subdural Hematoma, left</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Marie Thompson's Disease</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>1:30</u> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>	
20g. COUNTY <u>St. Louis</u>		20h. STATE <u>Mo.</u>	
21. I attended the deceased from <u>1950</u> to <u>Sept 30, 1963</u> Death occurred at <u>1:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		21b. I last saw him alive on <u>Sept 30, 1963</u>	
22a. SIGNATURE (Degree or title) <u>masao Okamoto M.D.</u>		22b. ADDRESS <u>607 N. Grand</u>	
22c. DATE SIGNED <u>10/2/63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-3-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
24. FUNERAL DIRECTOR <u>Normeister Colonial Mortuary</u> <u>6464 Chippewa</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 2 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>			

Dr. Masao Ohmoto  
University Club Bldg.  
Room 317

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Eric C. Hanson*

Licensed Embalmer No. 4764

P. O. Address St Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.